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Eugene F. Diamond

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by

Eugene F. Diamond, M.D.

The author is director of the Linacre Institute

For the past fifteen years the hospice and palliative care literature has floated the concept of "terminal sedation" in the management of patients who are terminally ill and either in or out of hospice environment.[1] Guidelines for the performance of "terminal sedation" have been published during the past ten years.[2] Uncontrolled clinical studies have evaluated the course of patients on terminal sedation including survival expectations. Nevertheless, an acceptable definition of terminal sedation has not yet been published or achieved. This lack of a precise definition means that we must evaluate terminal sedation as something positioned somewhere in the spectrum from acceptable palliative care to positive euthanasia. This spillover has made it impossible to judge the morality of what is called "terminal sedation" as an entity since it is a term used by different clinicians for different practices.

The following is an adaptation of the various interpretations of terminal sedation according to Barilan.[6]

1) Controlled sedation. This would mean a session of sedation, presumably to relieve extreme and otherwise intractable suffering, which takes place in the context of terminal care. Sedation is thus understood as an episode of sedation (such as would be employed in transient situations such as panic attacks, agitation, intubation and mechanical ventilation, etc.) in which the patient is sedated during an extraordinary need for a specific length of time. This is an application of an old German concept called "duhrschlaf" or sleep through an extreme circumstance. It is presumed that the extraordinary indication would have a finite limit. In the context of terminal care this type of sedation might be intended to tide the terminal patient over a period of extraordinary fear, pain or anxiety but not projected until death.

2) Deep sedation from which the patient is deliberately kept from awakening until death supervenes. In this type of terminal sedation it is presumed that ordinary care continues. Corporeal needs such as assisted nutrition and hydration are continued. This patient may even be kept on a ventilator in unusual cases. The purpose of the deep sedation is to protect

the patient from extreme and otherwise uncontrollable suffering. Deep sedation may thus be considered under the rubric of pain control in which both psychic and somatic pain are precluded by reducing the patient to a state of drug-induced coma. Because of the continuation of ordinary care, the coma is not the cause of the patient's death but rather the underlying fatal disease supervenes.

3) Deep sedation as a form of euthanasia. The sedated patient is denied ordinary care and is left to dehydrate, starve, or even suffocate.

The provision of ordinary care is interpreted as futile or even degrading. This has been referred to as "slow euthanasia.[7] Others point to the intention of sedation rather than assisted suicide as being ethically relevant but this distinction is not morally compelling since the intention is that the patient not merely be sedated but also to die during the sedation.

4) "Terminal elation." This is a term suggested by Barilan as encompassing the use of psychoactive drugs to induce euphoria, hallucinations and other altered states of consciousness. This type of therapy goes beyond the use of SSR1 anti-depressant drugs to treat the depression of the dying. By extension, it would include hypnosis,[8] "Medical Marijuana" and the various forms of psychedelics used by different cultures to produce "voodoo death."

It is highly questionable to employ measures to reduce the patient to a short or repetitive "trips" to an oblivion of altered consciousness while removing him from reality or meaningful rapport with near relatives or the health care team.

According to the above classification, there is not much question as to the acceptability of Type 1, which is actually only the application of the modality of sedation to a patient in a particular stage of life. There is presumably an undeniable need for sedation as a therapeutic measure related to the exigencies of a terminal illness.

Likewise, Type 3 terminal sedation in which there is an overt attempt to hasten the patient's death by denying ordinary care is incontrovertibly an unacceptable measure, which clearly fits into the definition of active euthanasia. The purpose of the sedation is to obtund the dying patient to a state where the desire for ordinary care, including assisted hydration and nutrition is obliterated. The motive for this kind of terminal sedation is to accelerate the dying process by compounding the underlying disease with dehydration and starvation. The entrance of this type of terminal sedation into the nomenclature of hospice as an acceptable form of management is sinister and reprehensible. This is an "aid in dying" strategy that will realize one of the goals of the pro-euthanasia lobby, which is to desensitize the public to the acceptability of direct killing of patients. This has been both a covert and overt goal of the euthanasia movement since its founding.[9]

Type 2 terminal sedation in the classification above can be the focus of moral ambivalence. In this technique, terminal sedation is employed in a deliberate attempt to keep the patient from awakening as his inevitable and unpreventable terminal event proceeds. It is presumed that ordinary care including ANH will continue and that the patient will therefore die of an underlying fatal illness. This method admits of a dualistic Cartesian approach to the dying patient. The sentient, thinking patient is put away while the corporeal body is nourished or even ventilated.[6] The purpose is to protect the patient from extreme suffering or pain refractory to conventional analgesia. Some argue that the intention is sedation and not death[8] and it is significant that recent studies indicate that this type of sedation does not shorten the lives of terminal patients.[10]

The timing of the initiation of this type of terminal sedation would be crucial since it would foreclose any conscious access to spiritual counseling and the sacraments, any possibility of negotiations with or reconciliation with near relatives, and the possible merit of offering up of suffering for personal sanctification.

Within the parameters of **a)** the continued employment of ordinary care, **b)** timing at a point where any meaningful rapport with near relatives and the health care team have ceased, and **c)** strict adherence to the intention to sedate and not to kill, it would seem that this type of terminal sedation could be morally diffusible. Conventional approaches to dying such as the employment of sufficient doses of opiates and other potent pain control and the retention of consciousness and human contact would continue to be the preferred management.

Dying patients have four basic fears characteristically. 1) The fear of pain, 2) The fear of catastrophic costs, 3) The fear of isolation and, 4) The fear of loss of control. All of these fears can be controlled under ideal circumstances of terminal care and the hospice movement has been an important development in harmonizing and facilitating the palliative care of the dying. Some patients do seem to have a morbid preoccupation with the avoidance of senility and dependence on machines. A misguided response to these anxieties is certainly a hazard for caretakers who may see euthanasia as a last resort of palliation especially in the context of inappropriate wishes of fearful patients.

It is crucial that terminal sedation not become a measure to expedite and control the dying process especially among those at-risk populations such as the demented, those dependent on public financial support and those afflicted with lingering and resistant terminal illnesses.

Properly motivated and ethically constructed terminal sedation, while not always intrinsically immoral, would require better standards, better definition, and better oversight than we currently have in place.

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